FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042168

Facility Name: Colonial Manor

Address: 620 Warrington Avenue (Number) Danville (City) 61832 (Zip Code)

County: Vermillion

Telephone Number: (217) 446-0660 **Fax #** ( )

HFS ID Number: 371357323001

Date of Initial License for Current Owners: 1996

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,157	12,506	3,904	27,567	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	11,157	12,506	3,904	27,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.00%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,904

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,653	19,569		200,222		200,222	3,663	203,885			1
2	Food Purchase		128,461		128,461		128,461		128,461			2
3	Housekeeping	93,481	21,331		114,812		114,812	4	114,816			3
4	Laundry	68,104	14,564		82,668		82,668		82,668			4
5	Heat and Other Utilities			108,621	108,621		108,621	1,156	109,777			5
6	Maintenance	68,040	85,729	44,434	198,203		198,203	9,690	207,893			6
7	Other (specify):*											7
8	**TOTAL General Services**	410,278	269,654	153,055	832,987		832,987	14,513	847,500			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,357,647	98,251	5,659	1,461,557		1,461,557		1,461,557			10
10a	Therapy		300,975	333,008	633,983	(403,179)	230,804	74,848	305,652			10a
11	Activities	61,871	5,930		67,801		67,801		67,801			11
12	Social Services			3,999	3,999		3,999		3,999			12
13	CNA Training							1,302	1,302			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,419,518	405,156	351,066	2,175,740	(403,179)	1,772,561	76,150	1,848,711			16
	C. General Administration											
17	Administrative	49,808			49,808		49,808	56,168	105,976			17
18	Directors Fees							4,170	4,170			18
19	Professional Services			285,820	285,820		285,820	(274,235)	11,585			19
20	Dues, Fees, Subscriptions & Promotions			61,812	61,812	(45,443)	16,369	(4,685)	11,684			20
21	Clerical & General Office Expenses	125,345	10,641	14,412	150,398		150,398	115,937	266,335			21
22	Employee Benefits & Payroll Taxes			397,301	397,301		397,301	30,176	427,477			22
23	Inservice Training & Education			801	801		801	977	1,778			23
24	Travel and Seminar			10,298	10,298		10,298	(8,299)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,820	56,820		56,820	1,480	58,300			26
27	Other (specify):*			12,591	12,591		12,591	(12,150)	441			27
28	**TOTAL General Administration**	175,153	10,641	839,855	1,025,649	(45,443)	980,206	(90,461)	889,745			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,004,949	685,451	1,343,976	4,034,376	(448,622)	3,585,754	202	3,585,956			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Colonial Manor #0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			103,755	103,755		103,755	9,832	113,587			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,805	137,805		137,805	17,074	154,879			32
33	Real Estate Taxes			93,692	93,692		93,692		93,692			33
34	Rent-Facility & Grounds							5,078	5,078			34
35	Rent-Equipment & Vehicles			12,727	12,727		12,727	1,072	13,799			35
36	Other (specify):*											36
37	**TOTAL Ownership**			347,979	347,979		347,979	33,056	381,035			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					403,179	403,179		403,179			39
40	Barber and Beauty Shops			6,160	6,160		6,160		6,160			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,443	45,443		45,443			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			6,160	6,160	448,622	454,782		454,782			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,004,949	685,451	1,698,115	4,388,515		4,388,515	33,258	4,421,773			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(202)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(398)	20		17
18	Fines and Penalties				18
19	Entertainment	(16,027)	24		19
20	Contributions	(1,150)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,000)	27		24
25	Fund Raising, Advertising and Promotional	(7,813)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,634)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,892		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,892		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 33,258		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Colonial Manor

ID# 0042168

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(202)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(398)	20	17
18				18
19			24	19
20		(1,150)	27	20
21				21
22		(10,000)	19	22
23				23
24		(11,000)	27	24
25		(7,813)	20	25
26				26
27				27
28				28
29		0	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,563)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,663	0	0	0	0	0	0	0	0	3,663	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,156	0	0	0	0	0	0	0	0	1,156	5
6	Maintenance	0	0	9,690	0	0	0	0	0	0	0	0	9,690	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	14,513	0	0	0	0	0	0	0	0	14,513	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	74,848	0	0	0	0	0	0	0	0	0	74,848	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,302	0	0	0	0	0	0	0	0	1,302	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	74,848	1,302	0	0	0	0	0	0	0	0	76,150	16
	C. General Administration													
17	Administrative	0	0	56,168	0	0	0	0	0	0	0	0	56,168	17
18	Directors Fees	0	0	4,170	0	0	0	0	0	0	0	0	4,170	18
19	Professional Services	(10,000)	(275,820)	11,585	0	0	0	0	0	0	0	0	(274,235)	19
20	Fees, Subscriptions & Promotions	(8,211)	0	3,526	0	0	0	0	0	0	0	0	(4,685)	20
21	Clerical & General Office Expenses	0	0	115,937	0	0	0	0	0	0	0	0	115,937	21
22	Employee Benefits & Payroll Taxes	0	0	30,176	0	0	0	0	0	0	0	0	30,176	22
23	Inservice Training & Education	0	0	977	0	0	0	0	0	0	0	0	977	23
24	Travel and Seminar	(16,027)	0	7,728	0	0	0	0	0	0	0	0	(8,299)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,480	0	0	0	0	0	0	0	0	1,480	26
27	Other (specify):*	(12,150)	0	0	0	0	0	0	0	0	0	0	(12,150)	27
28	**TOTAL General Administration**	(46,388)	(275,820)	231,747	0	0	0	0	0	0	0	0	(90,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,388)	(200,972)	247,562	0	0	0	0	0	0	0	0	202	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Colonial Manor **#** 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	9,832	0	0	0	0	0	0	0	9,832	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44)	0	0	17,118	0	0	0	0	0	0	0	17,074	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,078	0	0	0	0	0	0	0	5,078	34
35	Rent-Equipment & Vehicles	(202)	0	0	1,274	0	0	0	0	0	0	0	1,072	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(246)	0	0	33,302	0	0	0	0	0	0	0	33,056	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,634)	(200,972)	247,562	33,302	0	0	0	0	0	0	0	33,258	45

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	275,820	Heritage Enterprises, Inc.	100.00%		(275,820)	4
5	V								5
6	V	10a	Adjustment for Related Organization	296,698	GreenTree Pharmacy	100.00%	371,546	74,848	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 572,518			$ 371,546	$ * (200,972)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,663	$ 3,663	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				4	4	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,156	1,156	19
20	V	6	Maintenance				9,690	9,690	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,302	1,302	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				56,168	56,168	29
30	V	18	Directors Fees				4,170	4,170	30
31	V	19	Professional Services				11,585	11,585	31
32	V	20	Fees, Subscription, Promotions				3,526	3,526	32
33	V	21	Clerical & General Office Expenses				115,937	115,937	33
34	V	22	Employee Benefits & Payroll Taxes				30,176	30,176	34
35	V	23	Inservice Training & Education				977	977	35
36	V	24	Travel and Seminar				7,728	7,728	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,480	1,480	38
39	Total			$			$ 247,562	$ * 247,562	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					9,832	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					17,118	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,078	20
21	V	35	Rent-Equipment & Vehicles					1,274	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 33,302	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises			50.00					$ 4,170	Ln 18	1
2	Carle Foundation			50.00							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 4,170		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	83	$ 3,663	1
2	2	Food Purchase	Beds	2,612	25	7	0	83	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	83	4	3
4	4	Laundry	Beds	2,612	25	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	83	1,156	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	83	9,690	6
7	7	Other	Beds	2,612	25	0	0	83	0	7
8	9	Medical Director	Beds	2,612	25	0	0	83	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	83	0	9
10	11	Activities	Beds	2,612	25	0	0	83	0	10
11	12	Social Service	Beds	2,612	25	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	83	1,302	12
13	14	Program Transportation	Beds	2,612	25	0	0	83	0	13
14	15	Other	Beds	2,612	25	0	0	83	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	83	56,168	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	83	4,170	16
17	19	Professional Services	Beds	2,612	25	364,592	0	83	11,585	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	83	3,526	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	83	115,937	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	83	30,176	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	83	977	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	83	7,728	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	83	1,480	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 247,562	25

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	83	$	1
2	30	Depreciation	Beds	2,612	25	309,426		83	9,832	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			83		3
4	32	Interest	Beds	2,612	25	538,695		83	17,118	4
5	33	Real Estate Taxes	Beds	2,612	25			83		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		83	5,078	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		83	1,274	7
8	36	Other	Beds	2,612	25			83		8
9	38	Medically Nec Transportation	Beds	2,612	25			83		9
10	39	Ancillary Service Centers	Beds	2,612	25			83		10
11	40	Barber and Beauty Shops	Beds	2,612	25			83		11
12	41	Coffee and Gift Shops	Beds	2,612	25			83		12
13	42	Other	Beds	2,612	25			83		13
14								83		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 33,302	25

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Busey Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 1,932,567	01/15/06	variable	$ 118,606	1
2	Busey Bank		xx	Mortgage								2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital				334,000			19,199	6
7	Busey Bank		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 2,266,567			$ 137,805	9
	B. Non-Facility Related*											
10	Interest Income										(44)	10
11												11
12	Allocated Interest										17,118	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 17,074	14
15	TOTALS (line 9+line14)						$	$ 2,266,567			$ 154,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Colonial Manor **#** 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	84,753	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	87,046	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,293	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	91,399	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	93,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	56,664	8
	2001	85,171	9
	2002	82,410	10
	2003	78,220	11
	2004	80,837	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Colonial Manor COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 0042168

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-07-102-025-0060	Colonial Manor	$ 21,040.00	$ 21,040.00
2.	23-07-102-015-0060		$ 65,843.00	$ 65,843.00
3.	23-07-102-019-0030		$ 165.00	$ 165.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,048.00	$ 87,048.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,996 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 111,000	1
2					2
3	TOTALS			$ 111,000	3

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	83				$ 1,709,475	$		$	$	$	4
5					33,000						5
6											6
7											7
8											8
	Improvement Type**										
9	Architect Fees			1997	46,312						9
10	Property @ 607 Cunningham			1997	50,000						10
11											11
12	Architect Fees			1998	15,039						12
13	Door Replacement			1998	6,993						13
14	Water Pump			1998	1,439						14
15	Generator Gaskets			1998	1,011						15
16	Hallway Door			1998	800						16
17	Canapy			1998	1,526						17
18	Dumpster Pad			1998	4,100						18
19	Iron Fence			1998	900						19
20	Floor Drain			1998	800						20
21	Railing			1998	900						21
22	Addition--Materials			1998	762,036						22
23	Addition--Labor			1998	48						23
24	Addition--Professional Fees			1998	7,546						24
25	Washer/Dryer Repair			1998	1,619						25
26	Addition--Materials			1999	181,865						26
27	Addition--Professional Fees			1999	3,782						27
28	WAN Building Materials			1999	4,698						28
29	Roof Repair			1999	1,783						29
30											30
31											31
32											32
33											33
34	C/O Allocation							9,832	9,832		34
35	Book Depreciation					83,879		83,879		682,923	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Window Replacements	2000	$ 3,005	$		$	$	$	37
38	Water Heater	2000	3,798						38
39									39
40	Nurse Call System	2001	24,949						40
41	Coax Cable	2001	945						41
42	Roof Sheathing	2001	1,314						42
43									43
44	Door Alarm	2002	2,383						44
45	Roof	2002	38,165						45
46	Water Heater	2002	3,656						46
47	Heater/Air Conditioning Unit	2002	1,843						47
48	Fire Dampers	2002	523						48
49	A/C Unit	2002	566						49
50	Security Door	2002	1,127						50
51	Dishwasher Motor	2002	1,129						51
52	Sealcoat Parking Lot	2002	1,955						52
53									53
54	Blackflow Prevention	2003	672						54
55	Repair/Replace Doors	2003	7,866						55
56	A/C Unit	2003	495						56
57	Fire Supression System	2003	1,286						57
58									58
59	Automatic Transfer Switch	2004	3,458						59
60	Aero Air Condensor	2004	1,508						60
61	Parking Lot Sealant	2004	2,379						61
62									62
63	Kitchen Air Handler	2005	2,855						63
64	Condensor	2005	2,086						64
65	A/C Unit	2005	995						65
66	Ramp and Rails	2005	808						66
67	A/C Condensor	2005	2,313						67
68	Concrete	2005	1,714						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,949,465	$ 83,879		$ 93,711	$ 9,832	$ 682,923	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,949,465	$ 83,879		$ 93,711	$ 9,832	$ 682,923	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,949,465	$ 83,879		$ 93,711	$ 9,832	$ 682,923	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 220,147	$ 19,876	$ 19,876	$		$ 178,757	71
72	Current Year Purchases	24,981						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 245,128	$ 19,876	$ 19,876	$		$ 178,757	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,305,593	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,755	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,587	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,832	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 861,680	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,799 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 137,538	$		$ 137,538	1
2	Licensed Speech and Language Development Therapist		hrs			5,316			5,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			158,521	2,277		160,798	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				371,546		371,546	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					31,633			31,633	13
14	TOTAL			$		$ 333,008	$ 373,823		$ 706,831	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,042	$	1
2	Cash-Patient Deposits	5,367		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	722,880		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,373		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(28,270)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 732,392	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,000		13
14	Buildings, at Historical Cost	2,949,464		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	245,127		16
17	Accumulated Depreciation (book methods)	(858,680)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,086,765		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,533,676	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,266,068	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,613	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,367		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,399		32
33	Accrued Interest Payable	9,817		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 303,196	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,266,567		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,266,567	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,569,763	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,696,305	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,266,068	$	48

***(See instructions.)**

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,493,168	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,493,168	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	203,137	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 203,137	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,696,305	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,435,339	1
2	Discounts and Allowances for all Levels	(1,320,093)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,115,246	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	935,397	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 935,397	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,014	12
13	Barber and Beauty Care	7,170	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	535,991	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(4,210)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 540,965	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,591,652	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	832,987	31
32	Health Care	2,175,740	32
33	General Administration	1,025,649	33
	B. Capital Expense		
34	Ownership	347,979	34
	C. Ancillary Expense		
35	Special Cost Centers	6,160	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,388,515	40
41	**Income before Income Taxes (line 30 minus line 40)****	203,137	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 203,137	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,966	2,170	$ 65,616	$ 30.24	1
2	Assistant Director of Nursing	1,968	2,160	45,348	20.99	2
3	Registered Nurses	14,384	15,407	302,449	19.63	3
4	Licensed Practical Nurses	19,339	20,274	316,456	15.61	4
5	CNAs & Orderlies	62,750	67,357	627,778	9.32	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	6,434	6,953	61,871	8.90	10
11	Social Service Workers			0		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,414	22,056	180,653	8.19	15
16	Dishwashers					16
17	Maintenance Workers	5,926	6,645	68,040	10.24	17
18	Housekeepers	11,683	12,557	93,481	7.44	18
19	Laundry	8,323	8,785	68,104	7.75	19
20	Administrator	1,900	2,080	49,808	23.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,173	9,093	125,345	13.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,260	175,537	$ 2,004,949 *	$ 11.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		8,400		36
37	Medical Records Consultant		1,400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,980		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,999		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,779		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Black	admin		$ 49,808
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,808

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fees	$ 275,820
		0
		0
		0
		10,000
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 285,820

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,683
Unemployment Compensation Insurance	32,527
FICA Taxes	153,379
Employee Health Insurance	166,784
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	16,928
Employee Benefits - central office	30,176
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,477

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	402
Health Care Worker Background Check	
(Indicate # of checks performed)	280
Central Office Allocation	3,526
Promotional Advertising	2,635
Public Relations	5,178
Dues and Subscriptions	5,242
License and Fees	642
Less: Public Relations Expense	(5,178)
Non-allowable advertising	(398)
Yellow page advertising	(2,635)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,684

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	5,645
	78
Seminar Expense	4,575
	(16,027)
	7,728
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,443**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **1,492**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-6,237,593	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	0	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
QUALITY NURSING CARE		
NURSING SUPPLIES-PRIVATE	-107,749	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-535,991	
DRUGS-OTHER		
PT-PRIVATE	-935,397	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	1,328,093	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-7,170	
ACTIVITY FUND INCOME	0	
ACTIVITY FUND EXPENSE	-2,014	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-9,597	
RESIDENT TRANSPORTATION	3,460	
MISC INCOME	750	
GENERAL & ADMINIST WAGES	119,615	125,345
ADMINISTRATOR WAGES	49,808	49,808
VACATION & SICK - G&A	5,730	
EMPLOYEE BENEFITS	14,928	397,301
EMPLOYEE HEPETITIS VACCINE	0	
EMPLOYEE SCHOLORSHIP WAC	0	
EMPLOYEE SCHOLORSHIP COST	0	
DIRECTORS FEES		
OFFICE SUPPLIES	10,641	10,641
TELEPHONE	14,412	14,412
TRAINING & EMPLOYEE DEVL	801	801
GENERAL TRAVEL	5,645	10,208
MEAL EXPENSE FOR TRAVEL	78	
EDUCATION & SEMINAR	4,575	
HELP WANTED ADVERTISING	402	61,812
PROMOTIONAL ADVERTISING	2,635	
PUBLIC RELATIONS	5,178	
LICENSES & FEES	49,075	
DUES & SUBSCRIPTIONS	5,242	
CONTRIBUTIONS	1,150	
PROFESSIONAL FEES	10,000	295,020
AUDIT & ACCOUNTING FEES	8,400	8,400
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	1,400	
PHARMACIST FEES	1,980	
SOC SERV/ACT CONSULT	3,999	3,999
TV RENTAL	354	
INCOME TAXES		12,591
BACKGROUND CHECKS	280	
PAYROLL TAXES	180,736	
PAYROLL TAXES ADMINIST	1,170	
WORKMENS COMP	165,700	
LIABILITY INSURANCE	54,820	56,820
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	27,683	
CENTRAL OFFICE FEES	275,020	
BAD DEBTS	11,000	
LOST ITEMS-RESIDENTS	441	
MISCELLANEOUS	0	
REAL ESTATE TAXES	93,692	93,692
LEASED EQUIPMENT	12,373	12,727
MAINTENANCE SALARIES	63,117	68,040
MAINTENANCE SICK & VAC	4,923	
ELECTRIC	80,580	100,621
NATURAL GAS	45,453	
HEATING & DIESEL OIL		
WATER & SEWER	22,788	
TRASH COLLECTION	20,560	44,434
PROPERTY PLANT REPLACEMN	63,786	85,729
GENERAL REPAIR & MAINT	42,943	
MAINTENANCE CONTRACTS	23,865	
DIETARY WAGES	168,867	180,653
DIETARY SICK & VAC	11,786	
SALES TAX		
FOOD PURCHASES	129,953	138,461
SUPPLIES-DISHWASHING	3,588	19,569
DIETARY REPLACEMENT	2,167	
DIETARY SUPPLIES-PAPER	13,981	
MEAL CREDIT	-1,492	
LAUNDRY WAGES	63,504	68,104
LAUNDRY SICK & VAC	4,600	
LAUNDRY REPLACEMENT	4,729	14,564
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	9,835	
HOUSEKEEPING WAGES	87,974	93,481
HOUSEKEEPING SICK & VAC	5,507	
HOUSEKEEPING SUPPLIES	4,886	21,331
HOUSEKEEPING SUPPLIES-PPR	16,445	
RN WAGES-MEDICARE		1,357,447
RN WAGES-NON MEDICARE	377,147	
RN WAGES	45,648	
ADON	45,548	
RN SICK & VACATION	25,102	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	296,238	
LPN WAGES OTHER		
LPN SICK & VACATION	20,218	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	571,107	
WARD CLERKS		
AIDE VACATION & SICK	52,571	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	0	0
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	0	
REHAB SICK & VAC	0	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	83,093	98,251
NURSING SUPPLIES	7,103	
REPLACEMENT-NURSING	8,055	
NURSING-OTHER	2,279	5,659
DRUG PURCHASES	147,664	306,975
DRUG PURCHASES-OTHER	151,014	
LABORATORY SERVICES	31,633	333,008
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITIES WAGES	58,620	61,871
ACTIVITIES SICK & VAC	3,251	
ACTIVITIES SUPPLIES	5,930	5,930
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	158,521	
PT SUPPLIES	2,277	
SOCIAL SERVICE WAGES	0	0
SOCIAL SERVICE SICK & VAC	0	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	137,538	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	5,316	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	6,160	6,160
BEAUTY SHOP SUPPLIES	0	0
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	137,885	137,885
DEPRECIATION	103,755	103,755
LOAN FEE AMORTIZATION	0	
INTEREST INCOME	-44	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	0	
	4,388,471	4,388,515
		44
	-269,137	
	(NET INCOME)	
	0	